EXHIBIT "A"

PATIENT AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI) (HIPAA COMPLIANT)

TO: **Cayce T. Jehaimi, M.D., 15901 Bass Road, #102, Fort Myers, FL 33908**

Upon presentation of the original or copy of this authorization, I hereby authorize all persons, companies, entities, his/her/its agents, employees and associates, to provide and release a complete copy of all records in your possession regarding **YADIEL MAYO**, including the protected health information that is described below, to **Daniel R. Levine, Esquire, Padula Bennardo Levine, LLP, 3837 NW Boca Raton Blvd., Suite 200, Boca Raton, FL 33431,** its agents and employees.

This request is intended to be as broad as possible and include, but not be limited to, all medical, doctor, clinic and hospital files, documents and records pertaining to me, including all alcohol and drug abuse records protected under the regulations in Code 42 Federal Regulations, Part 2, if any; all psychiatric or psychological services records and counseling notes and records, if any; and all social services records, if any.

You are further authorized to provide the following protected health information:

All documents relating to my treatment, including but not limited to:

X-RAY Files, X-RAY report, Magnetic Resonance Imaging films, CT scans, billing statements, ledger cards, payment records, patient questionnaire, patient information record, medical examinations, medical tests, laboratory reports, medical reports, consultation reports, insurance reports, memos, correspondence, physical therapy records and reports, physical therapy billing records, EMS/Paramedic reports, worker compensation records, Social Service records, and all other written documents whatsoever, including but not limited to, records relating to Drug/Alcohol abuse, psychiatric testing and results, and any and all other records of a confidential nature, including sensitive information such as mental health, HIV, AIDS, substance abuse, sexual abuse and/or other related conditions.

This protected health information is to be used for the following purpose:

Litigation currently pending in federal court filed by patient.

This release may be revoked by a signed and properly dated written revocation, delivered to the hospital, doctor or health care provider, provided that this release cannot be revoked as to protected health information that had been previously released in reliance on this document.

I understand that a refusal to sign this form will not result in a denial of health care by the hospital or any other health care provider and that this release has not been coerced by a health care entity or any of its business associates. I further understand that once the PHI is disclosed, it may be re-disclosed to individuals or organizations that are not subject to the federal privacy regulations such as expert witnesses, litigants, insurance companies (subject to any confidentiality agreement in place in the litigation) and even may become public record if filed with a court of law (however, if filed with a court of law, it will be filed under seal).

This authorization will expire within 90 days of the date below. Please be advised that a copy of this release holds the same authority as an original.

I fully discharge and release from any liability any person, company or entity who produces records, files or other documents pursuant to this authorization.

My full name is Jany Mayo _____.
My date of birth is _____.
My Social Security Number is _____.

_____
SIGNATURE

STATE OF FLORIDA)
COUNTY OF _____)

The foregoing instrument was acknowledged before me by means of __ physical presence or __ online notarization, this ___ day of _____, 20__, by _____, who is personally known to me or who has produced _____ as identification.

_____
NOTARY PUBLIC, State of Florida

My Commission Expires: _____
Printed Name

PATIENT AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI) (HIPAA COMPLIANT)

TO: **Evans Valerie, M.D., Lee Physician Group, 16230 Summerlin Road, Suite 215, Fort Myers, FL 33908**

Upon presentation of the original or copy of this authorization, I hereby authorize all persons, companies, entities, his/her/its agents, employees and associates, to provide and release a complete copy of all records in your possession regarding **YADIEL MAYO**, including the protected health information that is described below, to **Daniel R. Levine, Esquire, Padula Bennardo Levine, LLP, 3837 NW Boca Raton Blvd., Suite 200, Boca Raton, FL 33431,** its agents and employees.

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This authorization will expire within 90 days of the date below. Please be advised that a copy of this release holds the same authority as an original.

I fully discharge and release from any liability any person, company or entity who produces records, files or other documents pursuant to this authorization.

My full name is Jany Mayo _____.
My date of birth is [redacted] _____.
My Social Security Number is [redacted] _____.

_____
SIGNATURE

STATE OF FLORIDA)
COUNTY OF _____)

The foregoing instrument was acknowledged before me by means of __ physical presence or __ online notarization, this ___ day of _____, 20__, by _____, who is personally known to me or who has produced _____ as identification.

_____
NOTARY PUBLIC, State of Florida

My Commission Expires: _____
Printed Name

PATIENT AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI) (HIPAA COMPLIANT)

TO: **Viraine S. Weerasooriya, M.D., Lee Physician Group, 16230 Summerlin Road, Suite 215, Fort Myers, FL 33908**

Upon presentation of the original or copy of this authorization, I hereby authorize all persons, companies, entities, his/her/its agents, employees and associates, to provide and release a complete copy of all records in your possession regarding **YADIEL MAYO**, including the protected health information that is described below, to **Daniel R. Levine, Esquire, Padula Bennardo Levine, LLP, 3837 NW Boca Raton Blvd., Suite 200, Boca Raton, FL 33431,** its agents and employees.

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My date of birth is [redacted] _____.
My Social Security Number is [redacted] _____.

_____
SIGNATURE

STATE OF FLORIDA)
COUNTY OF _____)

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_____
NOTARY PUBLIC, State of Florida

My Commission Expires: _____
Printed Name

PATIENT AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI) (HIPAA COMPLIANT)

TO: **Golisano Children's Hospital of SW Florida, 9981 S. Healthpark Drive, Fort Myers, FL 33908**

Upon presentation of the original or copy of this authorization, I hereby authorize all persons, companies, entities, his/her/its agents, employees and associates, to provide and release a complete copy of all records in your possession regarding **YADIEL MAYO**, including the protected health information that is described below, to **Daniel R. Levine, Esquire, Padula Bennardo Levine, LLP, 3837 NW Boca Raton Blvd., Suite 200, Boca Raton, FL 33431,** its agents and employees.

This request is intended to be as broad as possible and include, but not be limited to, all medical, doctor, clinic and hospital files, documents and records pertaining to me, including all alcohol and drug abuse records protected under the regulations in Code 42 Federal Regulations, Part 2, if any; all psychiatric or psychological services records and counseling notes and records, if any; and all social services records, if any.

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My Social Security Number is [redacted] _____.

_____
SIGNATURE

STATE OF FLORIDA)
COUNTY OF _____)

The foregoing instrument was acknowledged before me by means of __ physical presence or __ online notarization, this ___ day of _____, 20__, by _____, who is personally known to me or who has produced _____ as identification.

_____
NOTARY PUBLIC, State of Florida

My Commission Expires: _____
Printed Name

CERTIFIED AUTHORIZATION FOR RELEASE OF RECORDS
DEPARTMENT OF ECONOMIC OPPORTUNITY (DEO)

Reemployment Assistance (RA) Benefit Records • P.O. Box 5750 • Tallahassee • FL 32314-5750 • (800) 204-2418

This authorization is for the release of confidential information contained in the records of the Department of Economic Opportunity

A person receiving confidential RA information through use of this form in violation of Chapter 443, Florida Statutes, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083. § 443.1715(1), Florida Statutes

THIS AUTHORIZATION IS VALID FOR A PERIOD OF 60 DAYS FROM THE DATE SIGNED

INSTRUCTIONS: For all requests, SECTION II, III or IV of this form must be fully completed, as applicable. If the required SECTIONS are not fully completed, this may cause a delay or denial of access to the requested records. Mail completed request along with a self-addressed, postage paid envelope to: Department of Economic Opportunity, Reemployment Assistance Records, P.O. Box 5750, Tallahassee, Florida 32314-5750.

SECTION I – (Select all that apply)

- ☐ I am the Claimant/Claimant's representative requesting Claimant's information. No fee will be assessed. (Complete SECTION II).
- ☑ I am an Employer/Employer's representative requesting the Employer's information. No fee will be assessed. (Complete SECTION III).
- ☐ I am a party requiring an opposing party's information for a Reemployment Assistance proceeding. No fee will be assessed. (Complete Section II and III).
- ☐ I am a Third Party Requestor (a workers compensation carrier, a third party conferring a benefit or service upon a Claimant or Employer, or a representative of a Claimant or Employer). (Complete SECTION IV, and SECTIONS II and/or III).

The information I am requesting is:

- ☑ Entire File
- ☐ Printout of RA Benefit Payments History
- ☐ Wages Records Information
- ☐ Other (Please specify) _____

SECTION II – Claimant Information - Complete if requesting Claimant information.

Name: Jany Mayo Social Security Number (SSN) [redacted]

(Collection of your SSN is authorized by law and required for record retrieval. § 443.091, Florida Statutes. Your SSN will not be used for any other purpose.)

Address: 2901 6th Street W, Lehigh Acres, FL 33971

Street City State Zip Code

Date of Birth: [redacted] mm/dd/yyyy Telephone: (786) 282-5858

SECTION III – Employer Information - Complete if requesting Employer information.

Employer Name: American Health Reform Solutions, LLC d/b/a American Health Marketplace

Contact Name/Title: Alex B.C. Ershock, Esq. / Employer Counsel Telephone Number: (561) 544-8900

Address: Padula, Bennardo Levine, LLP, 3837 NW Boca Raton Blvd., Suite 200, Boca Raton, FL 33431

Street City State Zip Code

SECTION IV – Third Party Requestor

Requestor/Company Name:

Contact Name/Title: _____ Telephone Number: _____

Address: _____

Street City State Zip Code

NOTE: If you are a Third Party Requestor the certified signatures in Section V, provided on **page 2** of this form, must be completed.

CERTIFIED AUTHORIZATION FOR RELEASE OF RECORDS
DEPARTMENT OF ECONOMIC OPPORTUNITY (DEO)

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SECTION V –

Third Party Requestor Acknowledgment and Agreement of Records Requestor from SECTION IV

By signing and submitting this form, the requestor acknowledges and agrees to the following:

1. The Third Party Requestor acknowledges that he/she is a workers compensation carrier, a third party conferring a benefit or service upon a Claimant or Employer, or representative of a Claimant or Employer.
2. The Third Party Requestor, if a worker's compensation carrier, shall use the information provided only for the purposes of determining whether the Claimant identified in SECTION II of this form is eligible for workers' compensation and for the purposes of any mediation, negotiation, arbitration or litigation relating to the Claimant's claim for workers' compensation.
3. The Third Party Requestor shall store the information in a location and manner that is inaccessible to unauthorized persons and made available only to authorized persons with a need for access to the information.
4. The Third Party Requestor shall instruct all personnel having access to the information about the confidentiality requirements set forth in Chapter 443, F.S. and on this form.
5. The Third Party Requestor acknowledges that anyone who unlawfully discloses the confidential wage information is guilty of a second degree misdemeanor. s. 443.1715, F.S.
6. The Third Party Requestor acknowledges that DEO reserves the right to conduct an on-site inspection to assure the requirements of the law and this agreement are being met.
7. The Third Party Requestor agrees to pay any applicable costs associated with providing the data requested. Title 20 Part 603, Code of Federal Regulations.
8. The Third Party Requestor understands that the information requested may contain inaccuracies due to errors made by employers in their quarterly wage reports and the Department of Economic Opportunity shall not be responsible or liable for any errors contained in the information.

As the Third Party Requestor, I HEREBY ACKNOWLEDGE THAT I AM A PARTY ENTITLED TO THE INFORMATION IDENTIFIED IN SECTION I AND THAT THE INFORMATION CONTAINED IN THIS FORM IS ACCURATE AND TRUTHFUL.

Signature of Third Party Requestor _____ Date _____

Claimant/Employer Certification pursuant to 20 CFR 603.5(d)(2) - Required only where there is a Third Party Requestor.

By signing this form, the Claimant and/or Employer certifies and acknowledges the following:

1. I am the Claimant and/or Employer identified in SECTION II and/or III and that the information contained in this form is accurate and truthful. I authorize the release of my information to the requestor named in SECTION IV.
2. The release of the records identified herein provides a service or benefit to me.
3. **If this request involves a Workers Compensation Claim:** Section 443.1715(2)(b)1, Florida Statutes, provides: The Employer or the Employer's workers' compensation carrier against whom a claim for benefits under Chapter 440, Florida Statutes, has been made, or a representative of either, may request from the Department of Economic Opportunity records of wages of the Claimant reported by an Employer for the quarter that includes the date of the accident that is subject of such claim and for subsequent quarters. The request must be made with the authorization or consent of the Claimant or any Employer who paid wages to the Claimant subsequent to the date of the accident. The Florida Workers' Compensation Act provides that workers' compensation benefits shall be reduced by the amount of the reemployment assistance (or unemployment compensation) received (Section 440.15(10), F.S.). **To allow determination of the proper amount of workers' compensation, I hereby authorize release of reemployment assistance information relative to my account.**

Signature of person that is subject to this request. (Claimant/Employer) _____ Date _____